86-1.59 Capital expense reimbursement for DRG case based rates of payment. Capital expense shall not include capital expense allocated to exempt units and designated AIDS centers.

(a) The allowable costs of fixed capital (including but not limited to depreciation, rentals and interest on capital debt or, for hospitals financed pursuant to Article 28-B of the Public Health Law, amortization in lieu of depreciation, and interest and other approved expenses associated with both fixed capital and major movable equipment) and major movable equipment shall, with the exception noted in subdivisions (c), (g) and (h) of this section, be reimbursed based on budgeted data and shall be reconciled to total actual expense for the rate year and shall be determined and computed in accordance with the provisions of sections 86-1.23, 86-1-24, 86-1.29, 86-1.30 and 86-1.32 of this Subpart. In order for budgeted expenses to be reconciled to actual:

(1) Rates of payment for a general hospital shall be adjusted to reflect the dollar difference between budgeted capital related inpatient expenses included in the computation of rates of payment for a prior rate period and actual capital related inpatient expenses for the same prior rate period. For rates commencing April 1, 1995, if a factor for the reconciliation of budgeted to actual capital related inpatient expenses for a prior year is included in the capital related inpatient expenses component of rates of payment, such component shall be reduced by the difference between the applicable reconciled capital related inpatient expenses for such prior year, and capital related inpatient expenses for such prior year calculated based on a determination of costs related to services provided to beneficiaries of the Title XVIII federal social security act (Medicare) based on the hospital's average capital related inpatient expenses computed on a per diem basis.

(2) This amount shall be adjusted to reflect increases or decreases in volume for the same rate period.

(3) Capital related inpatient expenses included in the computation of payment rates based on budget shall not be included in the computation of

transferred out patient days and which shall be reconciled to actual rate year days) and the non-exempt hospital's average budgeted capital cost per day calculated using total non-exempt budgeted days. Budgeted capital costs shall be reconciled to actual capital costs for the non-exempt hospital in the rate year after these data are available based upon the on-Medicare share of capital costs derived by subtracting Medicare capital costs from total capital costs. Medicare capital costs shall be determined [by applying the relationship of Medicare ancillary charges to total ancillary times total inpatient ancillary capital costs] based upon the hospital's average capital related inpatient per diem. Total Medicare capital shall be these ancillary costs added to the routine portion of Medicare inpatient capital, adjusted for secondary payors.

(3) Allocation of payments for transfer patients and short-stay patients. Budgeted capital costs shall be allocated to payments for transferred patients and short-stay patients based on estimated non-exempt unit on-Medicare days reconciled to actual rate year days.

(f) Payment for budgeted allocated capital costs.

(1) Capital per diems for exempt units and hospitals shall be calculated by dividing the allocated non-Medicare capital costs identified in paragraph (e)(1) of this section by the 1985 exempt unit days, reconciled to rate year days and actual rate year exempt unit or hospital approved capital expense.

(2) Capital payments for DRG case-based rates shall be determined by dividing the budgeted capital allocated to such rates by the hospital's most recently available annual non-Medicare, non-exempt unit discharges, reconciled to rate year discharges

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For the rate period July 1, 1994 through December 31, 1994, the maximum allowable increase in the non-Medicare statewide average reported case mix in an historical rate year shall not exceed, on a cumulative basis when taking into consideration the rate of growth between the 1992 and 1987 rate years, six and two tenths percent from the adjusted 1992 non-Medicare statewide average reported case mix for 1994. For [~~rate years commencing~~] the rate period January 1, 1995 through March 31, 1995, the maximum allowable increase in the non-Medicare statewide average reported case mix shall not exceed, on a cumulative basis, three percent from the 1992 non-Medicare Statewide average case mix [~~for 1995~~]. For the rate period April 1, 1995 through December 31, 1995, the maximum allowable increase in the non-Medicare statewide average reported case mix shall not exceed, on a cumulative basis, two percent [~~and an additional one percent per year thereafter~~] from the 1992 non-Medicare statewide average reported case mix. For the rate period January 1, 1996 through June 30, 1996, the maximum allowable increase in the non-Medicare statewide average reported case mix shall not exceed, on a cumulative basis, three percent from the 1992 non-Medicare statewide average reported case mix. The maximum allowable increase shall be applied to adjust rates of payment for the periods commencing January 1, 1990 and thereafter, using the following methodology:

(i) the case mix adjustment percentage determined pursuant to this subparagraph plus the case mix adjustment percentage determined for the 1992 rate year, and further plus an adjustment to reflect the difference in measurement of the percentage change from 1992 rather than 1987 to maintain the effective maximum rate of allowable increase in non-Medicare statewide average case mix at two percent from 1987 for 1988 and one percent per year thereafter except for the period January 1, 1994 through December 31, [~~1994~~] 1995 as noted above; shall be multiplied by the hospital specific average reimbursable operating cost per discharge, the group average reimbursable operating cost per discharge and the basic malpractice insurance cost per discharge and the result subtracted from such amount before application of the service intensity weight for the applicable rate year determined pursuant to section 86-1.63 of this Subpart.

(a) A reported non-Medicare statewide increase in case mix index shall be determined by dividing the statewide rate year case mix index determined pursuant to paragraph (4) of subdivision (b) of section 86-1.75 by the statewide base year case mix index determined pursuant to paragraph (2) of subdivision (b) of section 86-1.75 and subtracting one from the result.

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statewide average capital cost per day for comparable exempt hospitals divided by exempt hospital patient days reconciled to actual total expense; and

(3) A health care services allowance of .614 percent for rate year 1994 and .637 percent for the period January 1, 1995 through June 30, 1995 of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(4) For the period July 1, 1995 through December 31, 1995, a health care services allowance of 1.42 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58; and

(5) For the period January 1, 1996 through June 30, 1996, a health care services allowance of 1.09 percent of the hospital's non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(c) Comprehensive Cancer Center Specialty Rates of Payment.

(1) Bone Marrow transplantation services provided in exempt comprehensive cancer centers shall be reimbursed, upon the request of a comprehensive cancer center therefore, on the basis of a separate per diem rate composed of:

(i)(a) An initial per diem operating cost component computed on the basis of allowable historical inpatient bone marrow transplantation operating expenses based on separately identifiable base year cost and statistical data for the bone marrow transplant unit. The base year Medicare share of these costs shall be removed in accordance with paragraph (a)(5) of this section. The non-Medicare exempt bone marrow transplant operating cost component shall be trended to the rate year pursuant to section 86-1.58 of this Subpart and further adjusted for changes in volume and case mix from the base year to the rate year using total reimbursable non-Medicare costs and statistics of the bone marrow transplant unit pursuant to section 86-1.64 of this Subpart. In the event that the bone marrow transplant unit is established subsequent to the comprehensive cancer hospital's base year, the initial per diem operating cost component shall be computed on the basis of separately identifiable budgeted costs and statistical data and subsequently adjusted to actual costs.

(b) The per diem rate shall be further adjusted to reflect costs incurred subsequent to the base year but not reflected in such base which are approved pursuant to section 86-1.61 of this Subpart.

(ii) A capital per diem cost component computed on the basis of budgeted capital costs allocated to the bone marrow transplantation unit, pursuant to the provisions of section 86-1.59 of this Subpart divided by the bone marrow transplantation unit patient days reconciled to actual total expense; and

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86-1.84 Supplementary Low Income Patient Disproportionate Share Adjustment.

(a) The [~~rates of~~]payment for the periods between January 1, 1991 through July 31, 1991 and August 1, 1991 through [~~December 31, 1995~~] **June 30, 1996** for persons eligible for federal financial participation under title XIX of the federal Social Security Act in medical assistance paid by State governmental agencies pursuant to Title 11 of Article 5 of the Social Services Law, shall include for eligible general hospitals a supplementary low income patient disproportionate share adjustment determined pursuant to subdivision (b) of this section. **The adjustment may be made to rates of payment or as aggregate payments to an eligible hospital.**

(b) The supplementary low income patient adjustment shall be determined by multiplying the applicable supplemental percentage coverage of need amount for the hospital as specified in paragraph (2) of this subdivision by the hospital's need as defined in subdivision (b) of section 86-1.65 of this Subpart and calculated using 1989 data for the period January 1, 1991 through December 31, 1993 and calculated using 1991 data for public hospitals, voluntary non-profit or private proprietary general hospitals for the period January 1, 1994 through [~~December 31, 1995~~] **June 30, 1996**. This amount shall be allocated to case payment and exempt units on the basis of non-Medicare reimbursable costs and divided by the service units of those Medicaid patients eligible for Federal financial participation under Title XIX of the federal Social Security Act in medical assistance pursuant to Title 11 of Article 5 of the Social Services Law, to arrive at the supplementary low income patient disproportionate share adjustment per unit of service.

(1) The low income patient percentage shall be defined as the ratio of the sum of inpatient discharges of patients eligible for medical

assistance pursuant to Title 11 of Article 5 of the Social Services Law, inpatient discharges of self pay patients* and inpatient discharges of charity care patients divided by total patient discharges expressed as a percentage. The percentages for the period January 1, 1991 through December 31, 1993 shall be calculated based on base year 1989 data from the statewide planning and research cooperative system (SPARCS), which was received by the Department no later than November 1, 1990. The percentages for the period January 1, 1994 through [~~December 31, 1995~~] **June 30, 1996** shall be calculated based upon 1991 data from the statewide planning and research cooperative systems (SPARCS), which was received by the Department no later than November 1, 1993.

***NOTE:** **Self-pay patients represent patients who are uninsured and who are not full pay patients**

(2)(i) The scale utilized in the development of a hospital's supplementary low income patient disproportionate share adjustment for the period January 1, 1991 through June 30, 1991 shall be as follows:

Low Income Patient Percentages	**Supplemental Percentage Coverage of Need**
50+ to 55%	5.0%
55+ to 60%	10.0%
60+ to 65%	15.0%
65+ to 70%	22.5%
70+ to 75%	30.0%
75+ to 80%	37.5%
80+	45.0%

(ii) The scale utilized for development of a hospital's supplementary low income patient adjustment for the period August 1, 1991 through [~~December 31, 1995~~] June 30, 1996 for a public hospital and August 1, 1991 through September 30, 1992 for a voluntary non-profit or a private proprietary general hospital shall be as follows:

Low Income Patient Percentages	**Supplemental Percentage Coverage of Need**
35+ to 55%	20%
55+ to 60%	25%
60+ to 65%	30%
65+ to 70%	37.5%
70+%	45%

(iii) The scale utilized for development of a voluntary non-profit or private proprietary general hospital's supplementary low income patient adjustment for the period October 1, 1992 through March 31, 1993 and for the period January 1, 1994 through [~~December 31, 1995~~] June 30, 1996 shall be as follows:

Low Income Patient Percentage	**Supplemental Percentage Coverage of Need**
35+ to 50%	10%
50+ to 55%	20%
55+ to 60%	25%
60+ to 65%	30%
65+ to 70%	37.5%
70+	45%

For the period January 1, 1994 through [~~December 31, 1995~~] June 30, 1996 if the sum of the adjustments pursuant to this subparagraph would exceed $36,000,000 for a rate year, the supplemental percentage coverage of need scale pursuant to this subparagraph shall be reduced on a prorata basis so that the sum of such adjustments provided for the rate year shall not exceed $36,000,000.

(iv) The scale utilized for development of a voluntary non-profit or private proprietary general hospitals' supplementary low income patient adjustment for the period May 15, 1993 through December 31, 1993 shall be at 120% of the supplemental percentage coverage of need scale specified in paragraph (2) (ii) of this section.

(3) The supplementary low income adjustment shall be limited for rate periods during January 1, 1991 through December 31, 1993 such that this amount, when added to the distribution determined pursuant to subdivision (d) of section 86-1.65 of this Subpart for the rate period, plus for a major public general hospital, the amount of any supplementary bad debt and charity care disproportionate share payments determined pursuant to section 86-1.74 for the rate period shall not exceed 90 percent of need as described in subdivision (b) of section 86-1.65 of this Subpart and calculated using 1989 data. In addition, in order to be eligible for an adjustment pursuant to this section, the hospital shall not be eligible for distributions as a financially distressed hospital pursuant to section 86-1.65(d)(3) of this Subpart and the hospital must maintain its collection efforts to obtain payment in full from self-pay patients.

(c) The supplementary low income patient disproportionate share adjustment provided in accordance with this section for rate periods during January 1, 1991 through December 31, 1993 shall be adjusted to reflect actual distributions made pursuant to subdivision (d) of section 86-1.65 of this Subpart and section 86-1.74 of this Subpart and actual service units as defined in subdivision (b) of this section.

(iii) A bad debt and charity care allowance, a health care services allowance and a financially distressed allowance as determined pursuant to the provisions of section 86-1.65 of this Subpart.

(d) Rates of Payment for Acute Care Children's Hospitals. Hospital services provided to non-Medicare patients in acute care children's hospitals shall be reimbursed on a diagnosis-related group basis composed of:

(1) 1994 reimbursable operating costs computed on the basis of the hospital's reimbursable operating costs as defined in paragraph (a)(4) of this section and statistical data for the same period. The base year Medicare share of these costs will be removed in accordance with paragraph (a)(5) of this section. The non-Medicare hospital operating costs shall be trended to the rate year pursuant to section 86-1.58 of this Subpart and further adjusted for changes in volume and case mix from the base to the rate year using total reimbursable non-Medicare costs and statistics of the hospital pursuant to section 86-1.64 of this Subpart. The DRG specific operating cost component shall be computed utilizing one-hundred percent hospital specific reimbursable costs with no adjustment for long stay or high cost outliers pursuant to section 86-1.54(f)(1) and (3) of this Subpart.

(2) The acute care children's hospitals shall be eligible to participate in the financial incentives for the physician specialty weighting towards primary care.

(3) A capital cost component computed on the basis of budgeted capital costs allocated to the inpatient portion of the hospital pursuant to the provisions of section 86-1.59 of this Subpart, divided by the budgeted discharges and shall be reconciled to total actual expenses and discharges;

(4) A health care services allowance of .614 percent for rate year 1994 and .637 percent for rate year 1995 of the hospitals' non-Medicare reimbursement inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(5) Discrete long stay and high cost outlier rates of payment shall not be paid.

(d) For rates of payment for discharges in 1991 and thereafter, a general hospital having less than 201 certified acute non-exempt inpatient beds that is classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of Title XVIII of the federal Social Security Act (Medicare) since the hospital is located in a rural area as defined by federal law (see 42 U.S.C. section 1395 ww(d)(2)(D)) or defined as a rural hospital under state law may choose to have its DRG specific operating cost component be 100 percent of the hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined pursuant to section 86-1.54(a) of this Subpart multiplied by the service intensity weight for each DRG set forth in section 86-1.62 of this Subpart. In order to exercise this option for 1991 or subsequent rate years, the general hospital shall notify the Department of such election in writing by no later than December first of the preceding rate year or a later date as determined by the Commissioner.

(e) For discharges on April 1, 1995 and thereafter, the DRG case-based rates of payment for patients assigned to one of the twenty most common diagnosis-related groups, will be held to the lower of the facility specific amount or the average amount, as determined pursuant to subdivision (c) of this section for all hospitals assigned to the same peer group. The "average amount" is the average of the hospital specific amounts for all hospitals assigned to each peer group. The twenty most common diagnosis-related groups shall be determined using discharge data two years prior to the rate year, but excluding beneficiaries of title XVIII (Medicare) of the federal social security act and patients assigned to diagnosis-related groups for human immunodeficiency virus (HIV) infection, acquired immune deficiency syndrome, alcohol/drug use or alcohol/drug induced organic mental disorders, and exempt unit or exempt hospital patients.

(f) Effective July 1, 1995, rates of payment for inpatient acute care services shall be reduced by the Commissioner to reflect the elimination of operational requirements previously mandated by law, regulation promulgated in accordance with applicable standards and procedures for promulgating hospital operating standards, the Commissioner, or other governmental agency as follows:

(i) An aggregate reduction shall be calculated for each hospital based upon: the result of eighty-nine million dollars annually for 1995 and trended to the rate year, multiplied by a ratio based upon data two years prior to the rate year, consisting of hospital-specific case-based Medicaid patient days divided by total case-based Medicaid patient days summed for all hospitals.

(ii) the result of the hospital specific amount allocated to exempt units shall be based upon the ratio of hospital specific exempt unit Medicaid patient days to hospital specific total Medicaid patient days of which the result is divided by the hospital specific exempt unit Medicaid patient days to produce a

unit of service reduction in the per diem rates of payment.

(iii) any amount not allocated to exempt units shall be divided by case based discharges consisting of data two years prior to the rate year resulting in a per case unit of service reduction for payment rates.

(d) For rates of payment for discharges in 1991 and thereafter, a general hospital having less than 201 certified acute non-exempt inpatient beds that is classified as a rural hospital for purposes of determining payment for inpatient services provided to beneficiaries of Title XVIII of the federal Social Security Act (Medicare) since the hospital is located in a rural area as defined by federal law (see 42 U.S.C. section 1395 ww(d)(2)(D)) or defined as a rural hospital under state law may choose to have its DRG specific operating cost component be 100 percent of the hospital's hospital-specific average reimbursable inpatient operating cost per discharge determined pursuant to section 86-1.54(a) of this Subpart multiplied by the service intensity weight for each DRG set forth in section 86-1.62 of this Subpart. In order to exercise this option for 1991 or subsequent rate years, the general hospital shall notify the Department of such election in writing by no later than December first of the preceding rate year or a later date as determined by the Commissioner.

(e) For discharges on April 1, 1995 and thereafter, the DRG case-based rates of payment for patients assigned to one of the twenty most common diagnosis-related groups, will be held to the lower of the facility specific amount or the average amount, as determined pursuant to subdivision (c) of this section for all hospitals assigned to the same peer group. The "average amount" is the average of the hospital specific amounts for all hospitals assigned to each peer group. The twenty most common diagnosis-related groups shall be determined using discharge data two years prior to the rate year, but excluding beneficiaries of title XVIII (Medicare) of the federal social security act and patients assigned to diagnosis-related groups for human immunodeficiency virus (HIV) infection, acquired immune deficiency syndrome, alcohol/drug use or alcohol/drug induced organic mental disorders, and exempt unit or exempt hospital patients.

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(i) An aggregate reduction shall be calculated for each hospital based upon: the result of eighty-nine million dollars annually for 1995 and trended to the rate year, multiplied by a ratio based upon data two years prior to the rate year, consisting of hospital-specific case-based Medicaid patient days divided by total case-based Medicaid patient days summed for all hospitals.

(ii) the result of the hospital specific amount allocated to exempt units shall be based upon the ratio of hospital specific exempt unit Medicaid patient days to hospital specific total Medicaid patient days of which the result is divided by the hospital specific exempt unit Medicaid patient days to produce a

unit of service reduction in the per diem rates of payment.

(iii) any amount not allocated to exempt units shall be divided by case based discharges consisting of data two years prior to the rate year resulting in a per case unit of service reduction for payment rates.

(iii) A bad debt and charity care allowance, a health care services allowance and a financially distressed allowance as determined pursuant to the provisions of section 86-1.65 of this Subpart.

(d) Rates of Payment for Acute Care Children's Hospitals. Hospital services provided to non-Medicare patients in acute care children's hospitals shall be reimbursed on a diagnosis-related group basis composed of:

(1) 1994 reimbursable operating costs computed on the basis of the hospital's reimbursable operating costs as defined in paragraph (a)(4) of this section and statistical data for the same period. The base year Medicare share of these costs will be removed in accordance with paragraph (a)(5) of this section. The non-Medicare hospital operating costs shall be trended to the rate year pursuant to section 86-1.58 of this Subpart and further adjusted for changes in volume and case mix from the base to the rate year using total reimbursable non-Medicare costs and statistics of the hospital pursuant to section 86-1.64 of this Subpart. The DRG specific operating cost component shall be computed utilizing one-hundred percent hospital specific reimbursable costs with no adjustment for long stay or high cost outliers pursuant to section 86-1.54(f)(1) and (3) of this Subpart.

(2) The acute care children's hospitals shall be eligible to participate in the financial incentives for the physician specialty weighting towards primary care.

(3) A capital cost component computed on the basis of budgeted capital costs allocated to the inpatient portion of the hospital pursuant to the provisions of section 86-1.59 of this Subpart, divided by the budgeted discharges and shall be reconciled to total actual expenses and discharges;

(4) A health care services allowance of .614 percent for rate year 1994 and .637 percent for rate year 1995 of the hospitals' non-Medicare reimbursement inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(5) Discrete long stay and high cost outlier rates of payment shall not be paid.